MINUTES

MENTAL HEALTH SUBCOMMITTEE
of the
HEALTH CARE TASK FORCE

August 27, 2009

(Subject to approval of the Subcommittee)

Mental health subcommittee member in attendance were: Senators – Chairman Joe Stegner, Patti Ann Lodge and Tim Corder; Representatives – Sharon Block, Fred Wood and John Rusche. Legislative services staff present were: Amy Johnson and Paige Alan Parker.

Also in attendance were: Kathie Garrett, Partners in Crisis; Bruce Croffy and Julie Taylor, Blue Cross of Idaho; Department of Health and Welfare: Dick Armstrong, Director, Dick Schultz, Deputy Director of Health Services, Leslie Clement, Administrator of the Division of Medicaid, Pat Guidry, Division of Medicaid, Ross Edmunds, Division of Behavioral Health; Sara Stover, Department of Financial Management; Tammy Perkins, Office of the Governor; Crista Henderson, Idaho Association of Counties and Bonneville County; Woody Richardson, Intermountain Hospital; Skip Oppenheimer, Chairman, and Margaret Henbest, Behavioral Health Transformational Workgroup; Mike Brassey and Jeff Cilek, St. Luke's Regional Medical Center; Molly Steckel, Idaho Medical Association and Idaho Psychological Association; Amy Holly, Sarah Woodley and Mark Snow, Ph.D., Business Psychology Associates; Brent Reinke, Director, Idaho Department of Correction; Tim Olson, Danielle Rauscher and Lyn Darrington, Regence BlueShield of Idaho; Dr. Scott Sells, Parenting with Love and Limits Program; and Benjamin Davenport, Risch Pisca PLLC.

Chairman Stegner called the meeting to order at 8:10 a.m.

Chairman Stegner introduced Skip Oppenheimer. **Mr. Oppenheimer** is the Chairman of the **Governor "Butch" Otter's** Behavioral Health Transformational Workgroup, which was established by executive order in January of 2009, to review the Western Interstate Commission for Higher Education (WICHE) report on Idaho Behavioral Health System Redesign that was completed. The Workgroup is tasked with developing a plan for a coordinated, efficient, state behavioral health infrastructure with clear responsibilities, leadership authority and action; and providing for stakeholder participation in the development and evaluation of the plan. The executive order calls for the workgroup to report back to the Governor in December 2009. **Mr. Oppenheimer** is not a government employee but is a businessman.

Mr. Oppenheimer provided some background information. He is an Idahoan. His business interests include food manufacturing and distribution and commercial real estate development. Regarding health care, he has served on the Saint Luke's Hospital Board of Directors for ten years. He has been concerned with mental health issues.

The workgroup first met in April of 2009. Both **Senator Joe Stegner** and **Representative Sharon Block** have been attending workgroup meetings. At the April meeting, the workgroup reviewed the WICHE report. The workgroup's vision was adopted: "Idaho citizens and their families have appropriate access to quality services provided through the publicly funded mental health and substance abuse systems that are coordinated, efficient, accountable, and focused on recovery." The workgroup also established six goals:

- Increase the availability of, and access to, quality services;
- Establish a coordinated, efficient, state and community infrastructure throughout the entire mental health and substance abuse system with clear responsibilities and leadership authority and action;
- Create a comprehensive, viable regional or local community delivery system;
- Make efficient use of existing and future resources;
- Increase accountability for services and funding; and
- Provide authentic stakeholder participation in the development, implementation and evaluation of the system.

The workgroup met with WICHE representatives and began negotiating a contract with WICHE to provide services to further the workgroup's vision and goals. That contract was submitted to **Governor Otter** who determined that such a contract needs to be subject to competitive bid and that a larger range of options needs to be developed. The Governor expressed his concern that other state agencies are being asked to competitively bid their consultant contracts. Also, there was some concern that all of the studies being recommended by WICHE may not be needed.

The workgroup, according to **Mr. Oppenheimer**, is currently not using WICHE. It has created three working groups: **Sharon Herringfeld** is chairing efforts to secure the services of a part-time facilitator to help pull together the pieces of a complex system; **Charlie Novak, M.D**., is chairing a group addressing fundamental questions; and **Debbie Field's** group is undertaking an evaluation of what other states are doing to determine best practices. WICHE has been very good in documenting its work product and has provided a framework draft that lays out definitions, provides a draft Request for Information, defines performance-based contract for regional behavioral health authorities, and a framework for organizational structure.

Mr. Oppenheimer stressed that the workgroup is not rejecting the WICHE report. The workgroup's current efforts are more a process than a substantive change. The workgroup will continue to report to the Mental Health Subcommittee on a regular basis. **Margaret Henbest**, who serves on the workgroup, stated that the workgroup will seek a 90-day extension from the Governor to complete its report.

Senator Tim Corder asked how many vendors will be able to competitively bid on the consultative services contract. **Mr. Oppenheimer** responded that the workgroup is currently employing a different approach: utilizing its own facilitator, issuing smaller Requests for Proposals, and relying on local resources such as universities. **Representative John Rusche**

suggested that the universities may have unique views and encouraged the workgroup to use an outside facilitator.

Department of Health and Welfare Director Dick Armstrong expressed his surprise that the Governor did not sign the contract with WICHE, but noted that some of the studies included in the proposed WICHE contract were not needed. He stated that the Department understands the need to move in a new direction regarding mental health and that the effort going forward will be collaborative.

Representative Block stated that it is important to work in coordination with the Governor and the stakeholders. Buy-in is needed and the Legislature and the public need to be educated. She can understand the Governor's concern with the Request for Proposal process, since the public expects transparency.

Brent Reinke noted that another piece of the puzzle is the budget. He stated that slowing down may not be a bad thing given the reduced resources. There is a need to know the operating level.

Senator Stegner stated that he is convinced that the Governor's motivation in rejecting the proposed contract with WICHE was nothing more than his concern with taking an action that the Governor would not allow state agencies to undertake. **Mr. Oppenheimer** responded that the workgroup is now in transition and that the responses of the subcommittees at the Governor's workgroup meeting on September 28, 2009 should help. **Tammy Perkins** added that the Governor's rejection of the proposed WICHE contract was totally philosophical.

Leslie Clement, Medicaid Administrator, Department of Health and Welfare, made a PowerPoint presentation to the subcommittee on Medicaid Mental Health & Substance Abuse Benefits. A copy of this presentation may be obtained at the Legislative Services Office or online at: www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm#mentalhealth. The presentation provided an overview of legislation and rule changes regarding mental health and substance abuse benefits from 2006 to the present. Among these changes were the adoption of HCR 48 (2006), which resulted in the establishment of a "Basic Plan," that eliminated partial care for participants that do not have serious mental health disorders and established mental health coverage limits and triggers for moving into the Enhanced Plan, and an "Enhanced Plan," that provides intensive treatment benefits and the addition of substance abuse coverage to Idaho's Medicaid program in 2008. **Ms. Clements** provided an analysis of the mental health benefits currently being provided by the Department:

"As Is"	**"To Be"**	**Status**
Partial Care: not best practice; Not focused on therapeutic interventions.	Phase-out partial care & add intensive outpatient benefit; Consider peer supports.	Reduced partial care benefits in year-one; Propose adding new benefits.

PSR: excessive use without concrete service outcome specifications.	Reduce weekly amounts: Skill training expectations added.	Implemented through rule.
Prior-authorization process onerous.	Transition from widget-approach to comprehensive case management.	In transition.
Hospital & ER use high.	Add evidenced-based benefit: partial hospitalization.	Under review.
Collateral contact excessive use.	Clarify appropriate use; Limit.	Implemented through rule.
Lack of supported services.	Add supported housing, supported employment . . .	Under review; waiver options.

Senator Corder asked whether savings are actually being realized following the reduction of authorized services. **Ms. Clement** replied that actual savings are being realized despite the increase in emergency room usage by clients. Costs are being avoided due to reductions in benefit levels. She stated that more does not necessarily mean more effective. She expressed confidence that the mental health benefits being provided by the Department are well managed.

Ms. Henbest asked whether the 79 individuals with higher utilization rates could be interviewed to determine the reasons for this higher utilization. **Pat Guidry** said that efforts were made to speak to some participants but they did not want to talk. Efforts have been made to review medical records. Some individuals had incidents that were out of their control such as a family member being incarcerated or the house burning down. Others simply chose to seek services outside the plan. **Representative Rusche** commented that some individuals may be sent to the emergency room by a physician and encouraged that the medical home model be investigated for "frequent fliers."

Senator Stegner inquired about partial hospitalization model. **Ms. Guidry** stated that this model provides hospital level of care without the costs. There is daily direct contact with a physician or nurse in a secure facility. The individual can go home at night. This model serves as a transition from in- patient to out-patient status.

Regarding where the Department needs to go in the future, **Ms. Guidry** stated that the Department needs to know what the result will be when providing new benefits. This will require administrative oversight. Broad licensing regulations are not in place. When these Medicaid benefits were first implemented, the Department was just paying the bills. To retroactively impose an oversight mechanism becomes difficult. Training and monitoring mechanisms are needed before a program is implemented.

Senator Stegner suggested that a Psychosocial Rehabilitation (PSR) Services special certification, as used in other states, might be of some help. **Ms. Clement** agreed. **Ms. Guidry** added there is a national association that sets standards and guidelines and issues certificates.

Representative Block thanked **Ms. Clement** and stated that a collaborative process with the Governor and the Legislature is the reason for success. **Ms. Henbest** expressed her appreciation that the Department is not trying to get in front of the Behavioral Health Workgroup, which is using the Department as a resource on issues being addressed.

Senator Stegner expressed concern regarding the limitation of anti-depression psychotic drugs through Medicaid. **Ms. Clement** stated that the Pharmacy and Therapeutic Committee, made up of practitioners, meets six times a year and receives information on pharmaceuticals and their costs. The Committee makes recommendation on preferred drugs. All drugs are available to practitioners. Initially, the Committee stayed away from making recommendations on atypical anti-psychotic drugs but has become more confident in that area. Drug company representatives attend the Committee meetings and patients have recently provided input as well. Drugs included on the preferred list are available for rebates.

Representative Rusche commented that the role of the Pharmacy and Therapeutic Committee is to make determinations regarding the comparative effectiveness of drugs. Such determinations result in winners and losers that impact the drug companies. Effectiveness and side effects are difficult to measure. Testimony from patients who have switched from one drug to another is reasonable under these circumstances.

Bruce Croffy, M.D., Ph.D., Medical Director for Blue Cross of Idaho, presented with the assistance of a PowerPoint, titled "Federal Mental Health Parity," a copy of which is available in the Legislative Services Officer or online at www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm#mentalhealth. **Dr. Croffy** gave an overview of the federal Mental Health Parity Act of 2008. He noted several things that the Act does not do:

- It is not a mandate to provide mental health or substance abuse benefits;
- It does not mandate coverage of all mental health conditions;
- It does not eliminate medical management; and
- It does not affect small employers with 50 or fewer employees.

Under the Act, mental health/substance abuse provisions must be no less restrictive than the medical surgical benefits; financial parity requires the same deductibles, copayments, coinsurance and out-of-pocket expenses; and health plans may still have an aggregate lifetime limit and aggregate annual limit that is applied to both medical and mental health and substance abuse benefits. Final rules have not yet been released and are expected in October of 2009. A "phase-in" period may be needed. One purpose of the Act is to better integrate mental health benefits with other health benefits. **Dr. Croffy** noted that the National Alliance

on Mental Health has given Idaho a "D" grade on its mental health program. This is an improvement from the previous "F" grade.

Senator Stegner asked what the current debate was on national health care reform with regard to mental health parity. **Representative Rusche** noted that the basic Medicaid plan includes mental health benefits and that the Act would expand these benefits to large employers. **Dr. Croffy** responded that he was impressed with the lack of discussion regarding parity in the national health care reform debate. National health care reform proposals would be phased in over several years. There is no delay in the mental health parity provisions under the Act.

Kathie Garrett commented that Idaho ranks seventh in suicides and asked how the Act would address suicide prevention. **Dr. Croffy** stated that primary care doctors are not well equipped to deal with mental health issues. A good mental health benefit would better deal with this problem.

Tim Olson, Regence BlueShield of Idaho, provided the subcommittee a handout, "Roadmap to Federal Mental Health Parity," which is available in the Legislative Services Office. **Mr. Olson** stated that Regence operates in Utah, Washington, Oregon and Idaho and covers three million lives (230,000 in Idaho). Regence has offered mental health parity since 2006 in Washington and Oregon, but Idaho does not have a mental health parity law. **Mr. Olson** stated that Regence takes mental health parity seriously and is in compliance with federal law.

Most subscribers do not maximize their current benefits, according to **Mr. Olson**. Regence has not experienced a greater than two percent care cost increase as a result of mental health parity. Regence's behavioral health component is based on evidence-based guidelines. Regence is seeking improvements through network management whenever possible and is making sure that its behavioral health management delivers the best possible care with a judicious use of resources.

Sarah Woodley stated that Business Psychology Associates have been managing policy plans for ten years and have providers in 38 states. According to **Ms. Woodley**, mental health parity is a "win-win" proposition. Depression occurs at a high rate with other health problems, such as cancer and diabetes. Treating mental health at the same time primary health services are being provided yield benefits since the depressed use primary health services two times more frequently than the general population uses such services. **Ms. Woodley** stated that most insurance plans will cover mental health. Such coverage will result in cost savings by increasing productivity. She added that depression is treatable, with 80% of those being treated showing improvement within 90 days.

Ms. Woodley stated that the federal mental health parity law is protective of state parity laws if there is no conflict. The state of Idaho has three years of experience with mental health benefits for state employees.

Representative Rusche commented that the federal mental health parity law does not require such coverage for the government, small employers or individuals, and asked whether the state will be required to continue to provide mental health benefits under that federal law. **Ms. Woodley** responded that eight percent of carriers are eliminating the benefit, which will push people onto the state. **Representative Rusche** asked how that would impact the state hospitals. **Ms. Woodley** responded that there is a lack of services at every level in Idaho, but perhaps an opportunity would be created for local programs and private providers. **Crista Henderson** of Bonneville County expressed the concern that property taxes will end up paying for these people.

Scott Sells, Ph.D., delivered a PowerPoint presentation to the subcommittee, titled "Results of the PLL Program." PLL stands for "Parenting With Love and Limits," which is available at the Legislative Services Office and online at www.legislature.idaho.gov/sessioninfo/2009/interim/healthcare.htm#mentalhealth. PLL is **Dr. Sells** organization based in Savannah, Georgia. PLL was hired by the Idaho Department of Health and Welfare as a consultant to address current gaps in service within the Department's Division of Behavioral Health. PLL initiated a pilot project in Idaho, training children's mental health (CMH) workers, child welfare and juvenile probation officers in regions I through VII to use the PLL evidence-based model. One hundred forty-three families were involved in the pilot project (48 families involved in the Bannock County Department of Juvenile Justice). Four research questions were asked regarding the CMH statewide evaluation of PLL:

- Will the PLL program significantly improve parental engagement and total family involvement by 70% or greater;
- Will the PLL program lower overall lengths of stay from the current CMH average of 12 months and a current Psychosocial Rehabilitation (PSR) average of 24 months and help close existing cases without sacrificing effectiveness;
- Does the PLL program significantly lower the costs of care per child as compared with other services in CMH and PSR; and
- Will the PLL program help expand and improve services with CMH from a traditional severely emotionally disturbed population into the area of probation and the diversion of youth referred within the juvenile justice system?

According to **Dr. Sells**, the answers to these questions were:

- 74.1% of the families graduated from PLL (87.2% graduation rate for Bannock County);
- The PLL length of stay was 2.5 months;
- 51% of the PLL CMH cases were closed completely, with 3.7% remaining open only to receive medicine management;
- Closing cases within two to three months did not compromise effective outcomes;
- The average cost per child under PLL was $1,500, compared to $3,097 in CMH and $6,100 in PSR;

Senator Stegner asked how long the pilot project will be in place. **Ross Edmunds** of the Department of Health and Welfare replied that the initial project was intended for one year but was extended for a second year at the same level to maintain and to look at the potential for expansion. Currently there are no plans to extend or reduce. Guidance is being sought from the subcommittee on this matter.

Representative Block commented that from the teacher's perspective, the parent is the key. **Dr. Sells** added that parents need community support.

Representative Rusche stated that behavioral disorders cannot be treated without treating the family and asked how children were selected for the pilot program**. Dr. Sells** stated that children with an active psychosis were excluded. **Mr. Edmunds** stated that PLL was brought in to address children with behavior disorders. Parents needed help. Other interventions are required for bipolar disorders.

Senator Lodge stated that she has received phone calls from parents with children in programs that lack parental involvement. **Dr. Sells** responded that parents must be involved. The PLL program calls for motivational interviews with parents and the use of auxiliary resources to help parents.

Senator Corder asked about the 37 families who failed the program. **Dr. Sells** offered a number of theories to explain these failures: the therapists may have been inexperienced and did not use the program tools correctly; some parents may have been burned out; the right parent or guardian might not have been involved (sometimes the key person might be a grandparent); and transportation may have been an issue. **Mr. Edmunds** noted that in comparing the success rates for Bannock County and CMH, the skill of the therapist may have been a factor. Also, in Bannock County there was court-ordered parental participation in the program, while in CMH, parental involvement was voluntary.

Representative Wood asked how the PLL program was funded. **Mr. Edmunds** replied that the program was initially funded through a federal grant. For the ongoing program, moneys have been shifted from the CMH program. **Senator Stegner** asked what the approximate cost was. The reply was $315,000.

Senator Lodge moved that the minutes of the subcommittee's August 20, 2008, meeting be approved. Representative Block seconded. The minutes were approved without objection.

Chairman Stegner announced that the subcommittee would not meet in September and that the next meeting would be in October or November, at which time the subcommittee could expect an update from the Governor's workgroup.

The meeting was adjourned at 12:15 p.m.